

DBHDS CUSTOMIZED RATE APPLICATION

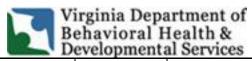
PROVIDER INSTRUCTIONS:

- This application should be submitted by the <u>provider</u> requesting a customized rate.
- Providers should read the <u>Customized Rate Provider Guidelines</u> prior to completing this form.
- Providers are required to submit this application electronically, in its original WORD format to: <u>DBHDScustomizedRate@DBHDS.Virginia.Gov</u>
- A secure link should be requested by emailing <u>DBHDScustomizedRate@DBHDS.Virginia.Gov.</u>
- Providers are requested to send <u>one</u> application per email.
- The form should be completed in its entirety using N/A for not applicable.

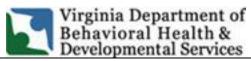
SECTION 1.	INDIVIDUAL/GENERAL INFORMATION
Date Submitted	Click here to enter the date the application is submitted.
Individual Name	LAST: Click here to enter text FIRST: Click here to enter text.
Individual DOB	Click here to enter the individual's Date of Birth .
Individual Medicaid #	Click here to enter the individual's Medicaid number .
Individual Social Security #	Click here to enter the individual's Social Security number .
Individual Level/Tier	LEVEL: Click here to enter text TIER: Click here to enter text
In what region are supports being provided?	Choose an item.
SECTION 2.	CSB/BEHAVIORAL HEALTH AUTHORITY/GENERAL INFORMATION
CSB/BHA	Click here to enter the individual's assigned CSB.
CSB Support Coordinator	Click here to enter the individual's assigned Support Coordinator .
CSB Support Coordinator Email	Click here to enter Email Address.
CSB Support Coordinator Phone #	Click here to enter phone Number.
SECTION 3.	PROVIDER/GENERAL INFORMATION
Provider Name	Click here to enter the Provider's Name.
Provider Point of Contact	Click here to enter the provider point of contact .
Provider Business Address	Click here to enter the provider street address . Click here to enter City, State, Zip
Address where supports will be provided	Click here to enter the address where supports will be provided. Click here to enter City, State, Zip
Provider phone and fax #	PHONE: Click here to the provider fax number. FAX: Click here to the provider fax number.
Provider Email	Click here to enter the provider's email address .
Is the individual a former resident of a training center?	Choose an item.
How many beds is the home licensed for?	Click here to enter the number of beds for which the home is licensed for.
How many individuals are supported in the home?	Click here to enter how many individuals are supported by the agency.
Under what service is a customized rate requested?	Please select the type of service under which you would like to apply for a customized rate



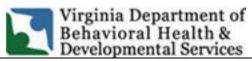
SECTION 4.	STAFFING	Стегора	ii Ciii C	ai Services	
How many shifts occur in a 24 hour period?	Click here to enter.				
	Shift		Numl	per of Individuals	Number of Staff
How many staff (per shift) provides support in the	Click here to enter.		Click here to enter.		Click here to enter.
home?	Click here to enter.		Click here to enter.		Click here to enter.
	Click here to enter.		Click here to enter.		Click here to enter.
	☐ THE INDIVIDUAL	REQUIR	ES IN	CREASED STAFFIN	G RATIO OF 1:1
	·	the individ	dual red	quires 1:1, listing all of the	e associated support needs.
	DAYS PER WEEK REQUIRING 1:1	HOURS DAY		INDICATE HOW MANY O THESE HOURS ARE PROVIDED BY HIGHER QUALIFED STAFF	EDUCATION AND EXPERTISE
1:1 Staffing	□Monday	Click her	e	Click here to enter text.	Click here to enter text.
TIT Swiming	□Tuesday	Click her	e	Click here to enter text.	Click here to enter text.
	□Wednesday	Click her	е	Click here to enter text.	Click here to enter text.
	□Thursday	Click her	e	Click here to enter text.	Click here to enter text.
	□Friday	Click here		Click here to enter text.	Click here to enter text.
	□Saturday	Click her	е	Click here to enter text.	Click here to enter text.
	□Sunday	Click here		Click here to enter text.	Click here to enter text.
	☐ THE INDIVIDUAL	REQUIR	ES IN	CREASED STAFFING	G RATIO OF 2:1
	Description: Click here to describe why	e associated support needs.			
	DAYS PER WEEK REQUIRING 2:1	HOURS DAY		INDICATE HOW MANY O THESE HOURS ARE PROVIDED BY HIGHER QUALIFED STAFF	EDUCATION AND EXPERTISE
2:1 Staffing	□Monday	Click her	e	Click here to enter text.	Click here to enter text.
	□Tuesday	Click her	e	Click here to enter text.	Click here to enter text.
	□Wednesday	Click her		Click here to enter text.	Click here to enter text.
	□Thursday	Click her	e	Click here to enter text.	Click here to enter text.
	□Friday	Click her	e	Click here to enter text.	Click here to enter text.
	□Saturday	Click her	e	Click here to enter text.	Click here to enter text.



	Sunday	Click here	Click here to enter text.	Click here to enter text.
SECTION 5.	STAFF QUALIFICATION	NS		
☐ The individual requires higher qualified staff to provide direct support	Please explain why the in Click here to enter text.	dividual requir	es expertise/specialized s	taff to provide direct support:
☐ The individual requires pro				
required; and who have a Mas below listed supports.	ter's degree or higher <u>or</u> a Ba	chelor's degree w	rith combined certifications (e.g. BCBA) to provide any of the
	(Check all	that apply and giv	ve a description)	
□ Direct support staff train evidence driven requiring a Click here to enter text.		_	are plan; training which is	evidenced based and/or
☐ Develop protocols and in resulting in outcomes that Click here to enter text.			ive and safe, evidence driv	en interventions/plans of care
☐ Monitor medical and/or needed as an individual nat Click here to enter text.	-		_	uding changing the protocols as
Serve as a liaison and provide expert opinion during hospitalizations or crisis interventions to ensure that protocols are maintained and/or amended as needed to reduce or prevent future hospitalizations (whether medical or behavioral). For individuals with a history of, or who are at risk of law enforcement involvement; staff must ensure that law enforcement and others are advised, trained or connected to mitigate the risk of legal system involvement or action. Click here to enter text.				
\Box Oversee overall medical or behavioral supports to ensure supports are effective and coordinated with external providers, CSB's, emergency services and that protocols address when and how to involve external providers. Click here to enter text.				
SECTION 6.	BEHAVIORAL SUPPO	RT NEEDS		
Mental Health/DSM-V Diagnosis	Click here to enter text.			
Behavioral strategies/interventions that have occurred over the past 6 months (e.g. ABA, Therapy, Positive Behavioral Supports)	Click here to enter text.			
Frequency and duration of interventions that have occurred over the past 6 months	Click here to enter text.			



	Developmental Services
Frequency and duration of behaviors that have occurred over the past 6 months	Click here to enter text.
Describe any history of hospitalizations, legal system involvement, or crisis services required over the past 12 months.	Click here to enter text.
SECTION 7.	MEDICAL SUPPORT NEEDS
Diagnosis	Click here to enter text.
Health Interventions Required	Click here to enter text.
Frequency of health supports required	Click here to enter text.
History of hospitalization(s) over the past 12 months	Click here to enter text.
SECTION 8.	OVERNIGHT SUPPORTS
Describe overnight support needs to include any 1:1 or 2:1 staffing requirements	Click here to enter text.
List the frequency of supports required during overnight hours	Click here to enter text.
SECTION 9.	DAY SERVICES CONTROL OF THE PROPERTY OF THE PR
Describe the individual's currently enrolled day services and/or activities	Click here to enter text.
Describe the specific skills or set of skills that the individual plans to build upon	Click here to enter text.
Describe any current barriers to participating in day services	Click here to enter text.
SECTION 10.	FUNDING
Describe all funding sources currently in use	Click here to enter text.
If there are services	Click here to enter text.
currently available to the individual but not in use,	
please give an explanation;	
especially as it relates to	
nursing services	



Describe the funding	Click here to enter text.
required to support the	
individual above and	
beyond currently utilized	
resources to include a	
breakdown of the specified	
cost	
SECTION 11.	SUPPORTING DOCUMENTATION/REQUIRED ATTACHMENTS
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Provide	ers are required to submit the following documentation with this application
	ers are required to submit the following documentation with this application cations submitted without proper supporting documentation can be denied ***
***Applic	•
***Applic	cations submitted without proper supporting documentation can be denied *** the provider-completed Plan for Supports (Part V).
***Applic ISP Parts I through IV and Behavioral Support Plan, w	cations submitted without proper supporting documentation can be denied *** the provider-completed Plan for Supports (Part V).
***Applical ISP Parts I through IV and Behavioral Support Plan, was Behavioral Data, where applications.	the provider-completed Plan for Supports (Part V). There applicable.
***Applical ISP Parts I through IV and Behavioral Support Plan, was Behavioral Data, where applications.	cations submitted without proper supporting documentation can be denied *** the provider-completed Plan for Supports (Part V). where applicable. plicable (history of crisis, frequency of behaviors and interventions required).
***Applicall ISP Parts I through IV and ISP Behavioral Support Plan, where apple Health supports data, when Imports data, when	cations submitted without proper supporting documentation can be denied *** the provider-completed Plan for Supports (Part V). where applicable. plicable (history of crisis, frequency of behaviors and interventions required).
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